Chapter II
Provider Participation Requirements

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Chapter II

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Managed Care Enrolled Members

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted Managed Care Organizations (MCOs) and their network of providers. All providers must check eligibility (Refer to Chapter 3) prior to rendering services to confirm which MCO the individual is enrolled. The MCO may require a referral or prior authorization for the member to receive services. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations.

Even if the individual is enrolled with an MCO, some of the services may continue to be covered by Medicaid Fee-for-Service. Providers must follow the Fee-for-Service rules in these instances where services are "carved out." The carved-out services vary by managed care program. For example, where one program (Medallion 3.0) carves out Early Intervention, the CCC Plus program has this service as the responsibility of the MCO. Refer to each program's website for detailed information and the latest updates.

There are several different managed care programs (Medallion 3.0, CCC, CCC Plus, and PACE) for Medicaid individuals. DMAS has different MCOs participating in these programs. For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO's network. The credentialing process can take approximately three (3) months to complete. Go to the websites below to find which MCOs participate in each managed care program in your area:

- Medallion 3.0:
  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC):
  http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

At this time, individuals enrolled in the three HCBS waivers that specifically serve individuals with intellectual and developmental disabilities (DD) (the Building Independence (BI) Waiver, the Community Living (CL) Waiver, and the Family and Individual Supports (FIS) Waiver) will be enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services will continue to be covered through the Medicaid fee-for-service program.

DMAS offers a web-based Internet option to access information regarding Medicaid or

FAMIS member eligibility, MCO enrollment, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

Field Code Changed

Provider Participation Requirements

All provider agencies and individuals who provide early intervention services must be certified to provide Early Intervention services. Certification is administered by the Department of Behavioral Health and Developmental Services (DBHDS). For information about provider certification through DBHDS, please contact the Infant & Toddler Connection at 804-786-3710 or on the web at www.infantva.gov.

Participating Provider

A participating provider is an agency, program, or person that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and that has a current, signed Participation Agreement with DMAS. Participating providers must also meet the practitioner qualifications set forth under Part C, abide by the Infant & Toddler Connection of Virginia Practice Manual and adhere to statutes and regulations governing Part C of IDEA.

Medicaid Program Information

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who is a member of a group using one central office may receive multiple copies of manuals, updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the Xerox/Provider Enrollment Unit (Xerox/PEU) at the address given under "Provider Enrollment" below.

Provider Enrollment

Any provider of services must be enrolled with the Department of Medical Assistance

Services (DMAS) prior to billing for any services provided to individuals who are enrolled in Medicaid/ Family Access to Medical Insurance Security Plan (FAMIS) Plus or FAMIS. A copy of the provider agreement with instructions on how to complete the forms can be found at the DMAS website, www.dmas.virginia.gov or by calling the Provider Enrollment Unit at 1-888-829-5373 (in state, toll-free), 1-804-270-5105 (Richmond area and out-of-state long distance), or via toll free fax at 888-335-8476. All providers must sign and complete the entire application and submit it to the Provider Enrollment/Certification Unit at:

Xerox State Healthcare, LLC
EDI Coordinator
Virginia Medicaid Fiscal Agent
P.O. Box 26228
Richmond, Virginia 23260-6228

An original signature of every individual provider is required. The Medicaid Participation Agreement may be time-limited depending on the licensing required. All participating Medicaid providers are required to complete a new application and agreement as a result of any name change or change of ownership.

~~Upon completion of the enrollment process, a ten-digit Atypical Provider Identifier (API) will be assigned as the provider identification number for non-healthcare providers.~~ Healthcare providers are required to submit their National Provider Identifier (NPI) ~~number. The API or NPI number~~number, which must be used on all claims and correspondence submitted to DMAS.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

Requests for Enrollment

All providers who wish to participate with Virginia Medicaid are being directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

Provider Screening Requirements

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as "limited", "moderate" or "high". Please refer to the table at the end of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the "high" level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. **The application fee requirements are also outlined in Appendix section of this provider manual.**

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied.

An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

Revalidation Requirements

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via our web portal.

Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

Ordering, Referring and Prescribing (ORP) Providers

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

Note: Early Intervention providers who are Community Service Boards or Local Health Departments are exempt from the ORP requirement.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

Please go to Chapter V of this provider manual to review the new billing procedures related to the implementation of these new screening requirements.

General Provider Participation Requirements

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements. Providers approved for participation in the Medicaid Program must perform the following activities as well as any others specified by DMAS:

- Immediately notify Xerox /PEU, in writing whenever there is a change in the information that the provider previously submitted. For a change of address, notify Xerox /PEU prior to the change and include the effective date of the change;
- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;
- Assure the recipient's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;
- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency ...." The provider should not attempt to collect from the recipient or the recipient's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative. The provider may not charge DMAS or a recipient for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;
- Use Medicaid Program-designated billing forms for submission of charges;
- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided;
- In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid recipients; and
- Hold information regarding recipients confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public.

Early Intervention Provider Requirements

Congress enacted Early Intervention legislation in 1986 as an amendment to the Education of Handicapped Children's Act (1975) to ensure that all children with disabilities from birth through the age of two would receive appropriate Early Intervention (EI) services. This amendment formed Part H of the Act, which was re-authorized in 1991 and renamed the Individuals with Disabilities Education Act (IDEA). When the IDEA was re-authorized in 1998, Part H became Part C of the Act. Virginia's statewide EI system is called the Infant & Toddler Connection of Virginia.

Providers must be enrolled with DMAS to perform and bill for EI services provided to Medicaid or FAMIS enrollees. Please note that providers who are already enrolled with DMAS in a provider category that is required to bill using the UB-04 claims form must re-enroll as an EI provider in order to be reimbursed for EI services as described in Chapter IV of this manual. More information about enrollment as a DMAS EI provider can be found above under the EI Provider Enrollment section of this chapter.

Providers of EI services must either be a Local Lead Agency (LLA) or must be affiliated by contract or memorandum of agreement with a LLA in order to provide EI services. "Local lead agency" means an agency under contract with the Department of Behavioral Health and Developmental Services (DBHDS) to facilitate implementation of a local EI

system as described in Chapter 53 of Title 2.2 (§ 2.2-5304.1) of the Code of Virginia.

A DMAS provider of EI services must have the administrative and financial management capacity to meet state and federal requirements, and have the ability to document and maintain individual case records in accordance with state and federal requirements.

All EI service providers participating in the Virginia Medicaid Medical Assistance Services Program and Managed Care Organizations (MCOs) must adhere to the requirements and provide services in accordance with State and Federal laws and regulations governing the provision of Early Intervention services, as well as both of the Early Intervention Practice Manuals (DMAS and DBHDS Part C).

~~A DMAS provider of EI services must adhere to and provide services in accordance with the Infant & Toddler Connection of Virginia Practice Manual, as well as State and Federal laws and regulations governing the provision of EI services.~~

Early Intervention Provider Enrollment

Early Intervention Individual Practitioners

All individual practitioners providing EI services must be certified to provide EI services. Certification is administered by the DBHDS. For information about practitioner certification through DBHDS, please contact the Infant & Toddler Connection at 804-786-3710, or visit www.infantva.gov for more information.

Qualified individuals listed in Appendix G of this manual who wish to receive their Early Intervention Certification in order to enroll as an EI provider can find information on the certification process at www.infantva.gov or they may contact:

Infant & Toddler Connection of Virginia
Office of Child and Family Services
DBHDS
1220 Bank Street
Richmond, VA 23218
804-786-3710

Certified EI Professionals who provide supervision of certified EI Specialists must document their ongoing clinical supervision of services provided by the EI Specialist and must maintain that documentation for at least three (3) years. If an EI professional observes an EI specialist during a service session, then both the EI professional and the EI specialist must sign the contact note.

All EI providers must be enrolled with DMAS for reimbursement of EI services. Providers

who are currently enrolled with DMAS as a Community Services Board, Outpatient Rehabilitation Agency, Home Health Agency, Private Duty Nursing, will need to complete an Early Intervention Attestation Letter and submit to:

Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803
888-335-8476 (Fax)

A sample EI Attestation Letter may be located online, under Early Intervention: http://dmasva.dmas.virginia.gov/Content_pgs/mch-home.aspx.

Providers other than a Community Services Board, Outpatient Rehabilitation Agency, Home Health Agency, Private Duty Nursing must complete the Early Intervention Provider Enrollment application and submit to Virginia Medicaid Provider Enrollment Services listed above. The Provider Enrollment applications may be located online at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderEnrollment.

Early Intervention Targeted Case Management

LLAs are designated by DBHDS to be responsible for either providing or contracting with another entity to provide the EI Target Case Management (also referred to as EI Service Coordination) for each locality in the Commonwealth. If a LLA subcontracts this service to another entity, it is the responsibility of the LLA to ensure that the EI Service Coordination agency meets all provider qualifications to provide EI services. This includes the service coordinator's qualifications to render EI Service Coordination services. Providers interested in providing EI Service Coordination should contact the LLA in their area for more information on providing this service.

Providers must be enrolled with DMAS as an EI Service Coordination provider to be reimbursed for EI Service Coordination services provided to Medicaid or FAMIS enrollees. The following two steps are necessary to become enrolled as a DMAS EI Service Coordination provider:

- Complete a new Early Intervention provider application and select "Case Management", and submit it to Virginia Medicaid Provider Enrollment Services as instructed on the application; and
- Have the LLA in the provider's locality complete and submit an Early Intervention Targeted Case Management Provider Information form (DMAS-57) to:

Virginia Medicaid Provider Enrollment Services
PO Box 26803

Richmond, VA 23261-6803
888-335-8476 (Fax)

Both of the forms mentioned above may be obtained from the DMAS website at: www.virginiamedicaid.dmas.virginia.gov. The DMAS-57 is also located in Appendix I of this Manual.

Early Intervention Service Coordination Qualifications

There are three parts to the EI Service Coordinator qualifications.

1. (a) A minimum of a bachelor's degree in any of the following fields:

   - Allied health, including rehabilitation counseling, recreation therapy, occupational therapy, physical therapy, or speech or language pathology;
   - Child and family studies;
   - Counseling;
   - Early childhood;
   - Early childhood growth and development;
   - Early childhood special education;
   - Human development;
   - Human services;
   - Nursing;
   - Psychology;
   - Public health;
   - Social work;
   - Special education – hearing impairments;
   - Special education – visual impairments;
   - Other related field or interdisciplinary studies approved by the State Lead Agency;

   or

   (b) An associate degree in a related field such as occupational therapy assistant, physical therapy assistant, or nursing;

   or

(c) A high school diploma or general equivalency diploma, or an undergraduate degree in an unrelated field, **plus** three years' full-time experience coordinating direct services to children and families and implementing individual service plans. Direct services address issues related to developmental and physical disabilities, behavioral health or educational needs, or medical conditions. Experience may include supervised internships, practicums, or other field placements. Parents' experience coordinating their child's services in Part C EI and in Part B early childhood special education will be considered to meet the requirement for full-time experience, and both the time coordinating their child's services in Part C and in Part B will count toward the requirement for three years' experience.

- Three years means 36 months or more.
- Full-time means 32 hours/week.

2. Completion of the Infant & Toddler Connection of Virginia online certification training modules, passing the competency test for each with at least 80% accuracy:

3. Completion of EI case manager certification process through DBHDS. For more information on the EI case manager certification, go to www.infantva.org or call, 804-786-3710.

EI Service Coordination Responsibilities

EI Service Coordination allowable activities include but are not limited to:

1. Coordinating the initial intake and assessment of the child and planning services and supports, including gathering background information from parents/guardians, gathering information from other sources, and participation in the development of Individualized Family Service Plans (IFSP), including initial IFSPs, periodic IFSP reviews, and annual IFSPs. This does not include performing medical assessments, but may include referral for such assessment;
2. Coordinating services and supports planning with other agencies and providers;
3. Assisting the child and family directly for the purpose of locating, developing, or obtaining needed services and resources;
4. Enhancing community integration through increasing the child and family's community access and involvement;
5. Making collateral contacts to promote implementation of the IFSP and allow the child/family to participate in activities in the community. Collateral contacts are defined as contacts with the child's significant others to promote implementation of

the service plan and community participation, including family, non-family, health care entities and others related to the implementation and coordination of services;

6. Monitoring implementation of the IFSP through regular contacts with service providers, as well as periodic face-to-face visits, such as the development of the IFSP, annual IFSPs, as well as IFSP reviews;
7. Developing a supportive relationship with the family that promotes implementation of the IFSP and includes coaching the family in problem-solving and decision-making to enhance the child's ability to participate in the everyday routines and activities of the family within natural environments where children live, learn, and play;
8. Coordinating the child/family's transition from EI services; and
9. Making contacts (face to face, phone, email, text) with the family.

Provider Responsibilities to Identify Excluded Individual and Entities

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded;
2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database; and
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS
Attn: Program Integrity/Exclusions
600 E. Broad St, Ste 1300
Richmond, VA 23219
-or-

E-mailed to: providerexclusions@dmas.virginia.gov

Requirements of the Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provisions for individuals with disabilities in the provider's programs or activities.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

Utilization of Insurance Benefits

The Virginia Medical Assistance Program is a "last pay" program. The only exception to this is the Part C program (34 CFR §303.510). Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, state, or local programs, other insurance, or third party liability. Health, hospital, Workers' Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare) -** Virginia Medicaid will pay the amount of any deductible or co-insurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid. However, the combined payment from Medicare and Medicaid cannot exceed the allowed amount under Medicaid had there been no other insurance.
- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.
- **Other Health Insurance** - When a consumer has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries** - DMAS will seek repayment from any settlements or judgments in favor of Medicaid consumers who receive medical care as the result of the negligence of another. If a consumer is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish any lien that may exist under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.
- **If there is an accident in which there is a possibility of third-party liability** or if the consumer reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 form to the attention of the Third Party Liability Unit, DMAS, 600 East Broad Street, Richmond, Virginia 23219. (To obtain a copy of this form, see the "Replenishment of Billing Materials" section in Chapter V of this manual.)

Termination of Provider Participation

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and Xerox-PEU 30 days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Virginia Medicaid – PES
P.O. Box 26803
Richmond, VA 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial.

Termination of a Provider Contract upon Conviction of a Felony

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Appeals of Adverse Actions

Provider Appeals

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse actions that afford appeal rights to providers.

A provider may appeal an adverse decision where a service has already been provided, by filing a written notice for a first-level Informal Appeal with the DMAS Appeals Division **within 30 calendar days** of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 6th Floor
Richmond, VA 23219

If the provider is dissatisfied with the first-level Informal Appeal decision, the provider may file a written notice for a second-level appeal Formal Appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia*, § 2.2-4000 et seq. The notice for a second-level Formal Appeal must be filed **within 30 calendar days** of receipt of the first-level Informal Appeal decision. The notice for second-level Formal Appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 6th Floor
Richmond, VA 23219

Administrative appeals of adverse actions concerning provider reimbursement are heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) (the APA), the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 et. seq. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

If the provider is dissatisfied with the second-level Formal Appeal decision, the provider may file an appeal with the appropriate county circuit court, in accordance with the APA and the Rules of Court.

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

The provider may not bill the recipient (client) for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider

any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Client Appeals

For client appeals information, see Chapter III of the Provider Manual.

EXHIBITS

The exhibits listed below can be accessed on the DMAS website at: www.dmas.virginia.gov.

- Mailing Suspension Request Form: http://www.dmas.virginia.gov/downloads/forms/Education_Services_Pkg.pdf.
- Early Intervention Targeted Case Management Provider Information form (DMAS-57) – Appendix I of this Manual.